

ILLINOIS DEPARTMENT OF PUBLIC HEALTH Podiatric Scholarship Program Application Academic Year 2016-2017

City		State	Zip Code
Phone:		E-mail:	
Home	Cell		
Date of Birth: ${\text{mm}/\text{m}}$	dd/ yyyy	Gender: _	Male Female
U.S. Citizen?	Yes No	If no, are you a lawful pe	ermanent resident? Yes No
	merican / Alaskan Na	tive Other (specify	an White, non-Hispanic
Name and location o	f the podiatric medi	cal school where you are	enrolled or admitted:
Anticipated graduation	on date?month / ye		Grade Point Average:
•	igations to provide ? If yes explain he	•	due to any loans, scholarships, grants,

Please answer the following questions, limiting your answers to one typed, single spaced page per question. Sign the answer, then append your answers to the application.

- 1. Describe any experience you have had with medically underserved populations. Include experiences you initiated, as well as experiences gain through your schooling.
- 2. Describe any experience(s) that significantly influenced your choice of health care career.
- 3. Describe your career goals, including the type of practice and setting you want.
- 4. Describe any special circumstances regarding your financial status.

RELEASE / CERTIFICATION STATEMENTS

By placing my signature on the line below, I agree to and certify the following:

- 1. The Illinois Department of Public Health (IDPH) is authorized to verify any and all statements in this application. I hereby authorize all persons and all entities, including educational institutions, to provide any information known about me to IDPH.
- 2. I am not in default on any obligations for any previously received state or federal loan funds.
- 3. All information submitted in this application is true, complete, and accurate in all respects. Any false statement shall be considered a default. If any information provided herein changes, I will update IDPH in writing, within 14 days of any change(s). Any failure to update IDPH due to such change(s) shall be considered a default.
- 4. Any educational institution which I attend is herewith authorized and directed to release any and all information requested by IDPH relevant to my grades, as well as my academic and financial standing.
- 5. If I receive a scholarship, I agree to commence practice on a full-time clinical basis at a medical facility in a Health Professional Shortage Area in Illinois as a podiatric physician. My practice will begin within 30 days after completion of a podiatric medical residency and licensure to practice podiatric medicine in Illinois. I will so practice for one full year for each year of scholarship assistance I receive from IDPH.

Signature:		Date:	
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The application must be received by the Illinois Department of Public Health no later than <u>September 16, 2016</u> and include the following:

- 1. Completed application form.
- 2. A copy of your notarized birth certificate, or documentation that you are a naturalized citizen, or documentation that you are a lawful permanent resident of the U.S.
- 3. A copy of your current Student Aid Report from your FAFSA application.
- 4. Proof of enrollment or letter of acceptance into a podiatric medicine program.
- 5. A copy of your official transcripts from your undergraduate or podiatric school (online printout of grades will not be accepted).
- 6. Completed narrative questions.

Send Application To:

Illinois Department of Public Health Center for Rural Podiatric Scholarship Program 535 West Jefferson Street, Ground Floor Springfield, Illinois 62761-0001